Health Insurance Claims Assessment (HICA) Act

General Information

What is the Health Insurance Claims Assessment (HICA) Act?

On September 20, 2011 Governor Snyder signed legislation creating the Health Insurance Claims Assessment (HICA) Act. Beginning January 1, 2012, certain third party administrators, carriers and self-insured entities are required to pay an assessment on certain paid health care claims. Please see Public Act 142 of 2011 and Treasury's Web site www.michigan.gov/businesstaxes for more information.

Who must pay the Health Insurance Claims Assessment (HICA)?

Generally, the Michigan HICA Act is levied upon certain insurance carriers, self-insured entities, employers, employee organizations, and third party administrators that pay health insurance claims for Michigan residents, for health-related services performed in Michigan. The assessment is levied upon the "paid claims" of those entities. MCL 550.1732(s). A company will be subject to the 1% assessment if they meet the definition of "carrier" or "third party administrator" under the Act. See MCL 550.1732(a), 550.1732(v).

However, the assessment is only owed once with respect to any single "paid claim." Where more than one entity may be subject to the assessment, such as an employer and its third party administrator, the statute provides a hierarchy to determine which entity is liable for paying the assessment. See MCL 550.1733(3).

How do I register as a Health Insurance Claims Assessment (HICA) payer?

Complete and submit *Form 4926, Electronic Funds Transfer Application - Health Insurance Claims Assessment* to Treasury.

I received a notification letter from Treasury, but do not believe I am subject to the Health Insurance Claims Assessment (HICA). What should I do?

Submit to Treasury a written letter of explanation detailing why you believe you are not subject to the HICA. Treasury will acknowledge receipt of your letter. A self-determination that you are not subject to the HICA is not binding on Treasury and is subject to potential review or audit at a later date. Mail the letter to:

Michigan Department of Treasury
Special Taxes Division – HICA
P.O. Box 30781
Lansing, MI 48909-8281

My business activity has changed, and I am no longer subject to the Health Insurance Claims Assessment (HICA). Who do I notify?

Submit to Treasury a written letter of explanation detailing why you believe you are you are no longer subject to the HICA. Treasury will acknowledge receipt of your letter. A self-determination that you are not subject to the HICA is not binding on Treasury and is subject to potential review or audit at a later date.

Mail the letter to:

Michigan Department of Treasury
Special Taxes Division – HICA
P.O. Box 30781
Lansing, MI 48909-8281

Who do I contact if I have questions about the Health Insurance Claims Assessment (HICA)?

Information about the Electronic Funds Transfer (EFT) process for making quarterly HICA payments is available by contacting the Michigan Department of Treasury at 517-636-0515.

Substantive questions regarding the HICA Act should be directed to Treas_Tax_Policy@michigan.gov.

Annual Return

How do I file the Health Insurance Claims Assessment (HICA) annual return?

The HICA annual return is e-filed directly to Treasury. Once logged into Treasury's e-file system, you will enter your annual return information into the online form. Commercial tax preparation software is not used to e-file the HICA annual return.

The HICA annual return e-file system will be available in December 2012, in advance of the first annual return due date of February 28, 2013.

How do I log in to gain access to e-file the Health Insurance Claims Assessment (HICA) annual return?

You will enter your HICA business account number, zip code and return year into Treasury's Web site, allowing you to gain access to the e-file system. If unable to gain access to the e-file interface, please call the Michigan Department of Treasury at (517) 636-0515 for assistance.

How will I know if Treasury has accepted my Health Insurance Claims Assessment (HICA) annual return?

Immediately following your selection to submit your HICA annual return, an online message will verify the acceptance of your submission. Once the HICA annual return information is submitted, you will be provided an option to print a paper copy with a confirmation number for your records.

If I paid Health Insurance Claim Assessment (HICA) during the return year, and my business was closed during the return year, do I qualify for the Proportional Credit if it is available for the return year?

Yes. Going out of business does not affect your eligibility to receive the Proportional Credit if it is available.

How do I receive a paper copy of my Health Insurance Claims Assessment (HICA) annual return for my records?

Once the HICA annual return information is submitted, you will be provided an option to print a paper copy with a confirmation number for your records. This will be your only opportunity to print a paper copy for your records.

Is there a way to save a partially completed Health Insurance Claims Assessment (HICA) annual return to come back and finish later?

No, you must complete and submit your HICA annual return in one session. If you exit before completion, all data will be lost.

Can I submit my Health Insurance Claims Assessment (HICA) annual return now, but make my payment at a later date?

Yes. Any assessment due on the HICA annual return must be remitted by the due date of the annual return, February 28. Please note, late submissions and payments are subject to penalty and interest.

If I make a mistake on my Health Insurance Claims Assessment (HICA) annual return, can I correct it?

Upon completion of your HICA annual return, you will have the opportunity to review the information before submitting, and can make changes at that time. Once submitted, changes cannot be made to the annual return. An amended return must be submitted.

Can I send in a paper Health Insurance Claims Assessment (HICA) annual return?

E-file is the preferred method for submitting the HICA annual return and ensures timely processing. If unable to e-file your return, please call the Michigan Department of Treasury at (517) 636-0515 for assistance.

How do I file the Health Insurance Claims Assessment (HICA) annual return if my business is located outside of the United States?

Please call the Michigan Department of Treasury at (517) 636-0515 for assistance on filing the HICA annual return.

If I discontinue my business during the year, when do I need to file the Health Insurance Claims Assessment (HICA) annual return?

The HICA annual return is due February 28. You may file your annual return any time before the annual return due date. Please note that the HICA e-file system will be available in January in advance of the annual return due date of February 28.

When will the Health Insurance Claims Assessment (HICA) annual return e-file system be available?

The HICA e-file system will be available in January in advance of the annual return due date of February 28.

On the annual return for the Health Insurance Claims Assessment (HICA) Act assessment, will we be expected to show gross paid claims and then each type of exclusion as a separate line item?

Both the quarterly worksheet and the annual return for the HICA Act assessment will require filers to show gross paid claims, with each type of exclusion from the gross amount separately calculated and shown as a separate line item. Filers will not be permitted to show only the net amount of paid claims.

Payment Information

How do I register as a Health Insurance Claims Assessment (HICA) payer?

Complete and submit *Form 4926, Electronic Funds Transfer Application - Health Insurance Claims Assessment* to Treasury.

How do I determine the amount of my quarterly Health Insurance Claims Assessment (HICA) payment?

Use *Form 4930, Quarterly Worksheet for Health Insurance Claims Assessment* to calculate your quarterly payment amount. The worksheet is your file copy and may be subject to audit. DO NOT MAIL the worksheet to Treasury.

How do I calculate penalty?

Penalty is 5 percent of the total unpaid HICA due for the first two months. After two months, 5 percent of the unpaid HICA amount is assessed each month. The maximum late penalty is equal to 25 percent of the unpaid HICA owed.

To assist in calculating penalty, you may use our Variable Penalty and Interest Calculator.

How do I calculate interest?

Interest is calculated using the current interest rate. To assist in calculating interest, you may use our Variable Penalty and Interest Calculator.

How do I register to make Health Insurance Claims Assessment (HICA) payments by Electronic Funds Transfer (EFT)?

To make HICA payments by EFT, complete and submit *Form 4926, Electronic Funds Transfer Application - Health Insurance Claims Assessment* to Treasury. Please allow at least four weeks for processing your EFT application. For more information on the EFT process, please visit our Web site, www.michigan.gov/biztaxpayments.

How will I know if Treasury has accepted my Health Insurance Claims Assessment (HICA) payment?

Verify your HICA payment was successfully processed by reviewing your banking statement.

Is there a way to review my Health Insurance Claims Assessment (HICA) payment history?

No, you should maintain complete records of your payment history for a period of four years after the assessment due date.

I believe I have overpaid on my quarterly Health Insurance Claims Assessment (HICA) payment, what should I do?

If you have overpaid on your quarterly payment, you may reduce your next quarterly payment by the amount of the overpayment. If requesting a refund of the overpayment, Michigan requires all refund requests to be submitted in writing. Refund requests should contain a brief explanation of the activity creating the overpayment. Refund requests should be mailed to:

Michigan Department of Treasury
Business Taxes Division - HICA
P.O. Box 30781
Lansing, MI 48909-8281

Can I submit a quarterly Health Insurance Claims Assessment (HICA) payment after the due date?

Yes, HICA quarterly payments can be submitted at any time. However, late payments are subject to penalty and interest.

Can I make more than one Health Insurance Claims Assessment (HICA) payment per quarter?

Yes, you may make multiple HICA payments for the same quarter. Quarterly payments are due April 30, July 30, October 30 and January 30.

Can I mail my Health Insurance Claims Assessment (HICA) payment?

No. HICA payments are required to be remitted by Electronic Funds Transfer (EFT). If unable to EFT your payment, please call the Michigan Department of Treasury at 517-636-0515 for assistance.

Is there a fee to submit Health Insurance Claims Assessment (HICA) payments using Electronic Funds Transfer (EFT)?

No. Submission of an ACH Debit payment is a free service offered by Michigan to allow taxpayers to quickly and accurately submit their HICA payments. If you will be submitting an ACH Credit payment contact your financial institution regarding any associated fees.

What is the format for submitting the Health Insurance Claims Assessment (HICA) quarterly payments?

HICA payments are required to be remitted by Electronic Funds Transfer (EFT). For more information on the EFT process, please visit our Web site, www.michigan.gov/biztaxpayments.

What should I do if my Health Insurance Claims Assessment (HICA) quarterly payment is due on a weekend, legal banking holiday or a holiday recognized by Michigan?

HICA quarterly payments are due April 30, July 30, October 30, and January 30. The annual return is due February 28 of the following year. . If the due date falls on a Saturday or Sunday, legal banking holiday or State holiday for Michigan, the returns and assessments are due on the next succeeding business day. Holidays observed by Michigan are listed on Form 3149.

Electronic Funds Transfer

What is an ACH Transaction?

ACH stands for Automated Clearing House, and is an electronic network for financial transactions in the United States.

How do I register to make Health Insurance Claims Assessment (HICA) payments by Electronic Funds Transfer (EFT)?

To make HICA payments by EFT, complete and submit *Form 4926, Electronic Funds Transfer Application - Health Insurance Claims Assessment* to Treasury. Please allow at least four weeks for processing your EFT application. For more information on the EFT process, please visit our Web site, www.michigan.gov/biztaxpayments.

What is the difference between an ACH Debit payment and an ACH Credit payment?

For an ACH Debit transaction, the taxpayer will contact Michigan's financial institution (or the State's contractor) to initiate a withdrawal of funds from the taxpayer's account and electronically transfer the amount to Michigan's account. For an ACH Credit transaction, the taxpayer contacts their financial institution to initiate an electronic transaction to withdraw funds from their account and transfer the amount to Michigan's account.

Do I need to notify my financial institution when making an ACH Debit payment?

Generally no. However some financial institutions offer a "Debit Blocking" or "Debit Filtering" service to prevent unauthorized debits (withdrawals) from an account. If an account has a debit block or filter, any unauthorized debit transactions will not be processed. Contact your financial institution and have the ACH transaction identified with the Company ID 9000000103 authorized to debit your account. Failure to make these arrangements may result in your payment request being rejected by your financial institution.

What is an International ACH Transaction (IAT)?

ACH payments associated with a foreign financial institution are classified as an IAT. If your domestic account is funded or otherwise associated with a foreign account, Treasury cannot accept an ACH Debit transaction and you must pay via an alternate method. As an alternative to ACH Debit, Treasury is able to accept IAT ACH Credit transactions. Contact your financial institution if you have questions about your account.

Is there a fee to submit Health Insurance Claims Assessment (HICA) payments using Electronic Funds Transfer (EFT)?

No. Submission of an ACH Debit payment is a free service offered by Michigan to allow taxpayers to quickly and accurately submit their HICA payments. If you will be submitting an ACH Credit payment contact your financial institution regarding any associated fees.

What is the format for submitting the Health Insurance Claims Assessment (HICA) quarterly payments?

HICA payments are required to be remitted by Electronic Funds Transfer (EFT). For more information on the EFT process, please visit our Web site, www.michigan.gov/biztaxpayments.

Technical Information

Is there a difference between the Health Insurance Claims Assessment (HICA) and "Intent to Assess" and "Final Assessment" letters?

The HICA Act (Public Act 142 of 2011) provides for an assessment on health care claims. Notice of Intent to Assess and Bill for Taxes Due (Final Assessment) are documents that are issued by the Michigan Department of Treasury when a taxpayer has an unpaid deficiency.

"Paid claims" is defined as actual payments, net of recoveries. Does "recoveries" encompass only amounts recouped from the provider, or does it include other amounts received by the payer, such as rebates or payments from third parties?

"Recoveries" includes any amounts received by the payer that are applied against a claim (and that affects the amount of the actual payment made to the provider).

Who is a Michigan resident for purposes of the Health Insurance Claims Assessment (HICA) Act?

The HICA Act applies to certain insurance carriers, third party administrators, and self-insured entities that pay health insurance claims for Michigan residents, for health-related services performed in Michigan. For purposes of the Act, Treasury will consider a Michigan resident to be a person who is domiciled in the State of Michigan on the date that the service in question is performed. "Domicile" means a place where a person has his true, fixed and permanent home and principal establishment to which, whenever absent there from, he intends to return. Domicile continues until another permanent establishment is established. As an example, under this definition, a person who is domiciled in Michigan, but attends college in Ohio, would be a Michigan resident. If that person obtained health services in Michigan while home between semesters, a "paid claim" for the performance of those services would be subject to the HICA Act assessment.

The Health Insurance Claims Assessment (HICA) Act provides for credits to be issued to payers when the assessment brings in more than $400 million in a year. When credits are issued due to the cap being reached, if the entity that deserves the benefit of the credit is no longer serviced by the third party administrator, or has no claims activity, should a refund be requested from the State so that a refund can be sent to the entity?

Sec. 3(6) of the HICA Act provides as follows:

> “If a third party administrator receives a credit or refund under this subsection, the third party administrator shall apply that credit or refund to the benefit of the entity for which it processed the claims under a service contract.” MCL 550.1733(6).

The Act requires third party administrators and carriers receiving credits to apply those credits to their next HICA payment. The Act does not provide a mechanism for requesting a refund of the credit amount under the circumstances described in the question. If the entity that should be receiving the benefit of the credit has no current claims activity, the third party administrator could apply the credit to the entity's account in case the entity has claims activity again in the future. However, if the entity is no longer serviced by the third party administrator at all, the statute does not require the third party administrator to locate and reimburse that entity.

The Health Insurance Claims Assessment (HICA) Act provides for a cap on the assessment of $10,000 "per insured individual or covered life annually." In the case of an individual using more than one insurer, is the assessment limited to $10,000 per insurer used by the individual? Or is the limit $10,000 total for all "paid claims" regardless of the number of insurers the individual has used in accumulating the claims?

As noted, the HICA Act uses the terms "insured individual" and "covered life." MCL 550.1733(4). While these terms are not defined in the Act, an individual person can be an "insured individual" or a "covered life" only with respect to a specific policy or program of insurance coverage. Therefore, Treasury has interpreted this provision to mean that the $10,000 cap will be applicable per insurer or third-party administrator.

Other taxes administered by Treasury typically have a filing threshold, below which the tax does not have to be paid. Is this true of the Health Insurance Claims Assessment (HICA) Act?

No. The HICA Act does not contain an exemption for filers owing assessment amounts below a certain *de minimis* threshold.

Entities Subject to HICA

Who must pay the Health Insurance Claims Assessment (HICA)?

Generally, the Michigan HICA Act is levied upon certain insurance carriers, self-insured entities, employers, employee organizations, and third party administrators that pay health insurance claims for Michigan residents, for health-related services performed in Michigan. The assessment is levied upon the "paid claims" of those entities. MCL 550.1732(s). A company will be subject to the 1% assessment if they meet the definition of "carrier" or "third party administrator" under the Act. See MCL 550.1732(a), 550.1732(v).

However, the assessment is only owed once with respect to any single "paid claim." Where more than one entity may be subject to the assessment, such as an employer and its third party administrator, the statute provides a hierarchy to determine which entity is liable for paying the assessment. See MCL 550.1733(3).

What health-related services are subject to the Health Insurance Claims Assessment (HICA)?

"Paid claims" subject to the assessment are defined, in part, as payments "made to a health and medical services provider." MCL 550.1732(s). "Health and medical services" is separately and very broadly defined under the Act. MCL 550.1732(j). All of the following are included in the definition of "health and medical services," and claims based on these services will be subject to the HICA Act assessment:

- Services included in furnishing medical care, dental care, pharmaceutical benefits, or hospitalization;
- Ancillary services including, but not limited to, ambulatory services and emergency and nonemergency transportation
- Services provided by physicians (including both M.D.s and D.O.s), nurses, dentists, chiropractors, acupuncturists, audiologists, optometrists, speech-language therapists, pharmacists, physical therapists, podiatrists, psychologists, occupational therapists, dietitians and nutritionists, social workers, and respiratory care therapists; and
- Behavioral health services, including, but not limited to, mental health and substance abuse services.

Additionally, the term "health and medical services" specifically excludes services provided by veterinarians, marriage and family therapists, athletic trainers, massage therapists, licensed professional counselors and sanitarians. MCL 550.1732(j)(*iii*).

Does the Health Insurance Claims Assessment (HICA) Act apply to non-taxable entities such as school districts and municipalities?

Yes. There is nothing in the language of the HICA Act that would specifically exempt non-taxable entities from the assessment, as long as they are otherwise a carrier, third party administrator, or self-ensured entity under the terms of the Act.

We are a licensed third party administrator in Michigan. We do not service any self-funded employers located in Michigan, but we do service employers in other states who have employees living in Michigan. Does the Health Insurance Claims Assessment (HICA) Act require the employer plan to be domiciled in Michigan, or does the assessment apply to any resident of Michigan who obtains health care services or prescriptions in Michigan, regardless of where his/her employer is located?

As a Michigan-licensed third party administrator, the Health Insurance Claims Assessment (HICA) is levied against you directly, rather than against the employer

plans that you provide services to. HICA applies to all "paid claims" of third party administrators. "Paid claims" does not include claims paid for services rendered to non-residents, nor does the term include claims paid for services to Michigan residents that are rendered outside of the State. Accordingly, the term includes claims paid for services provided to Michigan residents that are rendered in Michigan.

The only service provided by a licensed Third Party Administrator (TPA) in Michigan is health care and dependent care flex benefit administration for a client. The TPA receives the employees' payroll deductions for health and dependent care and makes reimbursements to these employees when they submit the required documentation showing out of pocket payments for co-pays etc. and dependent care costs. Are the payments made by the TPA subject to the assessment?

No. Pursuant to Section 2(s)(*viii*) of the Health Insurance Claims Assessment (HICA) Act, reimbursements made to individuals under a flexible spending arrangement are specifically excluded from the definition of "paid claims" subject to the assessment, provided that the flexible spending arrangement in question meets the definition of that term under Section 106(c)(2) of the Internal Revenue Code.

Are vision-related services subject to the Health Insurance Claims Assessment (HICA)?

Yes. The HICA is levied on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." Section 2(s). "Health and medical services" is broadly defined to include services provided by a physician or other practitioner including, but not limited to, health professionals (other than certain specifically excluded health professionals), along with "ancillary services." Section 2(j). Assuming that such services result in "paid claims," vision-related services provided by an optometrist or an ophthalmologist, as well as those provided by an optician (such as providing and fitting eyeglasses or contact lenses) would be subject to the HICA.

Is "durable medical equipment" subject to the Health Insurance Claims Assessment (HICA)?

Generally, yes. While that term is not specifically mentioned or defined in the statute, the HICA is levied on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." Section 2(s). "Health and medical services" is broadly defined to include "services included in furnishing medical care." Section 2(j). If services related to the provision of medical equipment result in "paid claims," such services would be

subject to the HICA, unless a specific statutory exemption applied to exclude those services.

Are claims for prescription drugs, purchased through a mail-order pharmacy and delivered to a Michigan resident, subject to the Health Insurance Claims Assessment (HICA)?

Yes. The assessment levied under HICA is on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." The term includes payments for claims for "service in this state by a pharmacy benefits manager." Section 2(s). "Health and medical services" is broadly defined to include services included in furnishing pharmaceutical benefits. Section 2(j)(i). Pharmaceutical services are provided to a Michigan resident "in this state" if the pharmaceuticals are delivered to that Michigan resident within the state of Michigan. This would apply to other mail-order prescription products as well, such as contact lenses, diabetic supplies, etc.

Are dental services subject to the Health Insurance Claims Assessment (HICA)?

Yes. The assessment levied under HICA is on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." Section 2(s). "Health and medical services" is specifically defined to include services included in "furnishing . . . dental care." Section 2(j)(i).

My company is self-insured, but we do use a Third-Party Administrator (TPA) for claims-related services. Can we pay the Health Insurance Claims Assessment (HICA) on our "paid claims" ourselves, or should the HICA be paid by our TPA?

The assessment levied under the HICA Act should be paid by the TPA. Both your company, as a self-insured entity, and your TPA, are potentially subject to the assessment under the HICA Act. However, the assessment is only owed once with respect to any single "paid claim." In this case, the statute provides a hierarchy to determine which entity must pay the assessment. The statute provides that "[a] group health plan sponsor shall not be responsible for an assessment … for a paid claim where the assessment on that claim has been paid by a third party administrator …" Section 3(2)(a). The statute further provides that the third party administrator "shall be responsible for all assessments on claims paid by the third party administrator." Section 3(2)(b).

Are carriers of Medicare supplemental insurance subject to the assessment under the Health Insurance Claims Assessment (HICA) Act? Should claims paid under Medicare supplemental coverage be included when determining the amount of the assessment that must be paid?

Yes, in both cases. Carriers of Medicare supplemental insurance will be subject to the HICA assessment if they meet the definition of "carrier" in the statute and they do not fall under any of the statute's specific exemptions. MCL 550.1732(a). There is no specific statutory exemption for carriers of Medicare supplemental insurance. These carriers, and claims paid pursuant to their coverage, are included in the assessment.

It appears that a group health plan sponsor will have to pay their assessment to the third party administrator and then the third party administrator will remit the assessment to Treasury. How can the health plan sponsor, shortly after the quarterly payment date, get confirmation from Treasury that the monies were received from the third party administrator?

While both a health plan sponsor and its third party administrator may be subject to the Health Insurance Claims Assessment (HICA) Act, the assessment is only owed once with respect to any single "paid claim." The statute provides a hierarchy to determine which entity must pay the assessment. The statute provides that "[a] group health plan sponsor shall not be responsible for an assessment … for a paid claim where the assessment on that claim has been paid by a third party administrator …" MCL 550.1733(2)(a). The statute further provides that the third party administrator "shall be responsible for all assessments on claims paid by the third party administrator." MCL 550.1733(2)(b). Accordingly, the third party administrator is responsible for paying the HICA Act assessment with respect to claims it pays on behalf of a group health plan sponsor. Michigan law prohibits Treasury from disclosing taxpayer information to third parties, except in certain specific situations. See MCL 205.28(1)(f). Therefore, Treasury is unable to provide information or confirmation to clients of third party administrators regarding assessments that have been paid on that third party administrator's "paid claims." Although Treasury will be unable to provide this type of information, employers, group health plan sponsors, and others using third party administrators should check with their third party administrators, who should be able to provide confirmation that the HICA assessment was properly paid with respect to claims paid on behalf of that entity.

Our company, located in Michigan, is a self-insured entity for worker's compensation only. Does the Health Insurance Claims Assessment (HICA) Act apply to payments made on worker's compensation claims?

No. The assessment under the HICA Act is levied on the "paid claims" of covered entities. The definition of "paid claims" specifically excludes claims paid for worker's compensation. See MCL 550.1732(s)(*iii*).

The Health Insurance Claims Assessment (HICA) Act refers to "ambulatory services" as one type of health and medical service that is subject to the assessment. What are "ambulatory services"?

"Ambulatory services" (referenced in MCL 550.1732(j)(*ii*) of the HICA Act) are medical services that are provided on an outpatient basis. Many medical treatments for acute illness and many preventive health care procedures can be performed on an ambulatory basis, including minor surgical and medical procedures, most types of dental services, dermatology services, and many types of diagnostic procedures (e.g., blood tests, X-rays, endoscopy and biopsy procedures of superficial organs). Accordingly, paid claims for minor surgical procedures performed at an outpatient surgery center would be subject to the HICA Act assessment, as would claims for diagnostic procedures such as colonoscopies, where the patient receives services in a hospital setting but is checked in and out on the same calendar day.

We are a third party administrator. Our clients have zero balance checking accounts and fund only claims to be paid, into their own individual bank accounts. If we pass through the Health Insurance Claims Assessment (HICA) Act assessment to our clients and they do not or cannot pay the pass-through amount, will we as the third party administrator be penalized? Who is responsible if the client goes bankrupt, and has no funds? How does the assessment get paid?

Although the Health Insurance Claims Assessment (HICA) Act permits covered entities to pass the amount of the assessment through to their clients or insureds, it is important to understand that the assessment is nevertheless levied directly upon carriers, self-insured entities and third party administrators. Third party administrators are required to pay the HICA Act assessment on claims that they pay or process, even if the claims are not paid from the assets or bank account of the third party administrator. The definition of "paid claims" under the statute includes payments that are made under a service contract for administrative services only. MCL 550.1732(s).

Accordingly, even if a client cannot or does not pay the amount passed through by the third party administrator, the third party administrator is still liable for paying the HICA, and will be assessed by Treasury for failure to do so. Applicable penalties and interest will be added to any amounts not paid when due. This is true regardless whether the client fails to pay a pass-through amount.

We are a third party administrator. We do not actually "pay" claims for our clients, we only process those claims. The funds to pay the claims come directly from our clients' bank accounts. Since we are not “paying” any claims, are we liable for the Health Insurance Claims (HICA) Act?

Under the statute, third party administrators are required to pay the HICA Act assessment on covered claims that they pay or process, even if the claims are not

paid from the assets or bank account of the third party administrator, and instead are funded directly by the third party administrator's client. The definition of "paid claims" under the statute includes payments that are made under a service contract for administrative services only. MCL 550.1732(s).

Does the Health Insurance Claims Assessment (HICA) Act apply to an indemnity only insurance product? For example, the insured suffers a broken arm and the carrier pays $500 directly to the insured, regardless of treatment expense?

No, the assessment under the HICA Act would not apply to claims paid under an indemnity-only insurance product, such as that described in the question. Under the statute, a "paid claim" means an actual payment made to a health and medical services provider, or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier. MCL 550.1732(s). A claim under an indemnity-only policy would not be a "paid claim" under this definition, because the payment associated with the claim would not be made to a health and medical services provider, nor would it be a reimbursement to an individual.

Are payments made pursuant to a health reimbursement account excluded from the Health Insurance Claims Assessment (HICA) Act?

Probably. Among the exclusions from the HICA Act's definition of "paid claims" upon which the assessment must be paid are "reimbursements to individuals under a flexible spending arrangement as that term is defined in section 106(c)(2) of the internal revenue code, … a health savings account as that term is defined in section 223 of the internal revenue code, … an Archer medical savings account as defined in section 220 of the internal revenue code, … a Medicare advantage medical savings account as that term is defined in section 138 of the internal revenue code, … or other health reimbursement arrangement authorized under federal law." MCL 550.1732(s)(viii). If a claim constitutes a reimbursement made to an individual under a health reimbursement account that is specifically authorized pursuant to federal law, that claim would be excluded from the HICA Act's definition of a "paid claim."

For services provided by a pharmacist, does the Health Insurance Claims Assessment (HICA) apply to the price of the pharmaceutical products or drugs?

Yes, a covered "paid claim" for pharmacy services or pharmaceutical benefits includes the cost of the pharmaceutical products or drugs. MCL 550.1732(s).

Does the Health Insurance Claims Assessment (HICA) apply to employers that self-insure for health care?

Yes. The HICA Act defines "carrier" to include an employer or employee organization that establishes or maintains a group health plan. MCL 550.1732(a). However, if a self-insured employer uses a third party administrator to pay its

health-care claims, under the hierarchy provided under the statute, the third party administrator would be responsible for paying the HICA assessment to Treasury. See MCL 550.1733(3)

If stop loss or excess insurance is purchased by a health plan sponsor, who is responsible for paying the Health Insurance Claims Assessment (HICA) on an excess claim? Is it the third party administrator, or the stop loss carrier?

In circumstances where two entities may both be subject to the HICA Act for the same claim, the statute provides a hierarchy to determine which entity must actually pay the assessment. In the case of a third party administrator and a stop loss or excess loss insurer, the statute provides as follows:

> "If there is both a third party administrator and an excess loss or stop loss insurer servicing the group health plan, the third party administrator shall be responsible for all assessments for paid claims that are not reimbursed by the excess loss or stop loss insurer and the excess loss or stop loss insurer shall be responsible for all assessments for paid claims that are reimbursable to the excess loss or stop loss insurer." MCL 550.1733(3)(d).

Accordingly, under this provision, the third party administrator will be responsible for the HICA assessment on "paid claims" up to the attachment point (the point at which the stop loss or excess loss coverage begins to apply), and the stop loss or excess loss carrier will be responsible for the assessment on the amount of each "paid claim" that exceeds the attachment point.

We are a third party administrator that is subject to the Health Insurance Claims Assessment (HICA) Act. Doctors and other providers often use billing services, and we frequently pay claims where the medical service provided is billed through such a billing service. However, there is not necessarily an indication on the claim where the actual service was performed, and the billing service is sometimes in a different state than where the doctor or provider is located. How do we handle these kinds of claims for purposes of the HICA assessment?

If the medical service upon which a claim is based was performed outside of Michigan, that claim can validly be excluded from a third party administrator's calculation of "paid claims" upon which the HICA assessment must be paid. *See* MCL 550.1732(s). However, in all cases, it is the burden of the entity claiming a right to an exclusion or exemption from a tax or assessment to prove its entitlement to that exclusion or exemption.

Thus, if a third party administrator excludes certain claims on the basis that the underlying medical services were not performed in Michigan, the third party administrator must be able to prove upon audit that the services associated with those claims were, in fact, not performed in Michigan. If the proliferation of medical providers using billing services, including out of state billing services, means that the billing address or other information on a claim does not provide reliable

evidence with respect to where the underlying medical service was actually performed, then it is incumbent upon the third party administrator to obtain additional information regarding the service performance location, if that claim is to be validly excluded. If the third party administrator is unable or chooses not to obtain that information, whether due to cost considerations or for other reasons, then those claims must be included in the calculation of "paid claims" that are subject to the HICA.

Most employees participate to some extent in the cost of their employer-sponsored health insurance. In anticipation of the Health Insurance Claims Assessment (HICA) being added on to our monthly health insurance billing statements by our carrier, as an employer, is there any rule restricting an employer from passing the cost of the HICA assessment on to its employees?

Nothing in the HICA Act addresses the relationship between an employer and its employees. Other laws, such as contract law and labor law, may govern that relationship, but the HICA Act itself is silent on this issue. Accordingly, the HICA Act itself neither permits nor prohibits an employer from passing the cost of the HICA on to its employees.

An employer pays a third party administrator to administer its wellness program, which includes a screening, a risk assessment, and an annual physical. Are such wellness expenses covered by the Health Insurance Claims Assessment (HICA)?

Yes. Wellness services such as those described in the question are not specifically excluded from the definition of "paid claims." *See* MCL 550.1732(s). In general, unless a type of health or medical service is specifically excluded from coverage under the statutory definition of "paid claims," claims based upon those services will be subject to the HICA.

If a payment from a health reimbursement account is made directly to a provider, would that payment be subject to the Health Insurance Claims Assessment (HICA)? The wording of the statute only specifically excludes payments made to individuals.

Among the exclusions from the HICA Act's definition of "paid claims" upon which the assessment must be paid are "reimbursements to individuals under a flexible spending arrangement as that term is defined in section 106(c)(2) of the internal revenue code, … a health savings account as that term is defined in section 223 of the internal revenue code, … an Archer medical savings account as defined in section 220 of the internal revenue code, … a Medicare advantage medical savings account as that term is defined in section 138 of the internal revenue code, … or other health reimbursement arrangement authorized under federal law." MCL 550.1732(s)(viii). If a claim constitutes a reimbursement made to an individual under a health reimbursement account that is specifically authorized pursuant to

federal law, that claim would be excluded from the HICA Act's definition of a "paid claim."

If the health reimbursement account meets the requirements for the statutory exclusion as stated above, the payments would not fall outside of the exclusion simply because they were made to a provider, rather than reimbursed to an individual. In this case, the payments would be made to the provider from the health reimbursement account at the specific direction of the individual account holder. Those payments would not constitute "paid claims" and would not be subject to the HICA Act assessment.

How should "domestic claims" between hospitals and their employees be treated for purposes of the Health Insurance Claims Assessment (HICA) Act? Typically, when a hospital employee has treatment at the employer hospital, a claim is submitted for eligibility verification and internal accounting purposes, but no money is paid to the hospital for the services provided.

The HICA Act assessment is levied upon the "paid claims" of carriers and third party administrators. "Paid claims" is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." MCL 550.1732(s). The "domestic claims" described in the question would not meet the definition of "paid claim" under the HICA Act, because there is no "actual payment" being made to a health and medical services provider. These claims would not be subject to the HICA Act assessment.

Does the Health Insurance Claims Assessment (HICA) Act apply to non-taxable entities such as school districts and municipalities?

Yes. There is nothing in the language of the HICA Act that would specifically exempt non-taxable entities from the assessment, as long as they are otherwise a carrier, third party administrator, or self-ensured entity under the terms of the Act.

Determining Which Entity Must Pay

Who must pay the Health Insurance Claims Assessment (HICA)?

Generally, the Michigan HICA Act is levied upon certain insurance carriers, self-insured entities, employers, employee organizations, and third party administrators that pay health insurance claims for Michigan residents, for health-related services performed in Michigan. The assessment is levied upon the "paid claims" of those entities. MCL 550.1732(s). A company will be subject to the 1% assessment if they meet the definition of "carrier" or "third party administrator" under the Act. See MCL 550.1732(a), 550.1732(v).

However, the assessment is only owed once with respect to any single "paid claim." Where more than one entity may be subject to the assessment, such as an employer and its third party administrator, the statute provides a hierarchy to determine which entity is liable for paying the assessment. See MCL 550.1733(3).

We are a third party administrator. Our clients have zero balance checking accounts and fund only claims to be paid, into their own individual bank accounts. Are we subject to the Health Insurance Claims Assessment (HICA) Act?

Although the Health Insurance Claims Assessment (HICA) Act permits covered entities to pass the amount of the assessment through to their clients or insureds, it is important to understand that the assessment is nevertheless levied directly upon carriers, self-insured entities and third party administrators. Third party administrators are required to pay the HICA Act assessment on claims that they pay or process, even if the claims are not paid from the assets or bank account of the third party administrator. The definition of "paid claims" under the statute includes payments that are made under a service contract for administrative services only. MCL 550.1732(s).

Accordingly, even if a client cannot or does not pay the amount passed through by the third party administrator, the third party administrator is still liable for paying the HICA, and will be assessed by Treasury for failure to do so. Applicable penalties and interest will be added to any amounts not paid when due. This is true regardless whether the client fails to pay a pass-through amount.

We are a third party administrator. We do not actually "pay" claims for our clients, we only process those claims. The funds to pay the claims come directly from our clients' bank accounts. Since we are not “paying” any claims, are we liable for the Health Insurance Claims Assessment (HICA) Act?

Under the statute, third party administrators are required to pay the HICA Act assessment on covered claims that they pay or process, even if the claims are not paid from the assets or bank account of the third party administrator, and instead are funded directly by the third party administrator's client. The definition of "paid claims" under the statute includes payments that are made under a service contract for administrative services only. MCL 550.1732(s).

Does the Health Insurance Claims Assessment (HICA) apply to employers that self-insure for health care?

Yes. The HICA Act defines "carrier" to include an employer or employee organization that establishes or maintains a group health plan. MCL 550.1732(a). However, if a self-insured employer uses a third party administrator to pay its health-care claims, under the hierarchy provided under the statute, the third party administrator would be responsible for paying the HICA assessment to Treasury. See MCL 550.1733(3).

My company is self-insured, but we do use a Third-Party Administrator (TPA) for claims-related services. Can we pay the Health Insurance Claims Assessment (HICA) on our "paid claims" ourselves, or should the HICA be paid by our TPA?

The assessment levied under the HICA Act should be paid by the TPA. Both your company, as a self-insured entity, and your TPA, are potentially subject to the assessment under the HICA Act. However, the assessment is only owed once with respect to any single "paid claim." In this case, the statute provides a hierarchy to determine which entity must pay the assessment. The statute provides that "[a] group health plan sponsor shall not be responsible for an assessment … for a paid claim where the assessment on that claim has been paid by a third party administrator …" Section 3(2)(a). The statute further provides that the third party administrator "shall be responsible for all assessments on claims paid by the third party administrator." Section 3(2)(b).

It appears that a group health plan sponsor will have to pay their assessment to the third party administrator and then the third party administrator will remit the assessment to Treasury. How can the health plan sponsor, shortly after the quarterly payment date, get confirmations from Treasury that the monies were received from the third party administrator?

While both a health plan sponsor and its third party administrator may be subject to the Health Insurance Claims Assessment (HICA) Act, the assessment is only owed once with respect to any single "paid claim." The statute provides a hierarchy to determine which entity must pay the assessment. The statute provides that "[a] group health plan sponsor shall not be responsible for an assessment … for a paid claim where the assessment on that claim has been paid by a third party administrator …" MCL 550.1733(2)(a). The statute further provides that the third party administrator "shall be responsible for all assessments on claims paid by the third party administrator." MCL 550.1733(2)(b). Accordingly, the third party administrator is responsible for paying the HICA Act assessment with respect to claims it pays on behalf of a group health plan sponsor. Michigan law prohibits Treasury from disclosing taxpayer information to third parties, except in certain specific situations. See MCL 205.28(1)(f). Therefore, Treasury is unable to provide information or confirmation to clients of third party administrators regarding assessments that have been paid on that third party administrator's "paid claims." Although Treasury will be unable to provide this type of information, employers, group health plan sponsors, and others using third party administrators should check with their third party administrators, who should be able to provide confirmation that the HICA assessment was properly paid with respect to claims paid on behalf of that entity.

If stop loss or excess insurance is purchased by a health plan sponsor, who is responsible for paying the Health Insurance Claims Assessment (HICA) on an excess claim? Is it the third party administrator, or the stop loss carrier?

In circumstances where two entities may both be subject to the HICA Act for the same claim, the statute provides a hierarchy to determine which entity must actually pay the assessment. In the case of a third party administrator and a stop loss or excess loss insurer, the statute provides as follows:

> "If there is both a third party administrator and an excess loss or stop loss insurer servicing the group health plan, the third party administrator shall be responsible for all assessments for paid claims that are not reimbursed by the excess loss or stop loss insurer and the excess loss or stop loss insurer shall be responsible for all assessments for paid claims that are reimbursable to the excess loss or stop loss insurer." MCL 550.1733(3)(d).

Accordingly, under this provision, the third party administrator will be responsible for the HICA assessment on "paid claims" up to the attachment point (the point at which the stop loss or excess loss coverage begins to apply), and the stop loss or excess loss carrier will be responsible for the assessment on the amount of each "paid claim" that exceeds the attachment point.

Most employees participate to some extent in the cost of their employer-sponsored health insurance. In anticipation of the new Health Insurance Claims Assessment (HICA) being added on to our monthly health insurance billing statements by our carrier as an employer, is there any rule restricting an employer from passing the cost of the HICA assessment on to its employees?

Nothing in the HICA Act addresses the relationship between an employer and its employees. Other laws, such as contract law and labor law, may govern that relationship, but the HICA Act itself is silent on this issue. Accordingly, the HICA Act itself neither permits nor prohibits an employer from passing the cost of the HICA on to its employees.

“Paid Claims”

"Paid claims" is defined as actual payments, net of recoveries. Does "recoveries" encompass only amounts recouped from the provider, or does it include other amounts received by the payer, such as rebates or payments from third parties?

"Recoveries" includes any amounts received by the payer that are applied against a claim (and that affects the amount of the actual payment made to the provider).

We are a licensed third party administrator in Michigan. We do not service any self-funded employers located in Michigan, but we do service employers in other states who have employees living in Michigan.

As a Michigan-licensed third party administrator, the Health Insurance Claims Assessment (HICA) is levied against you directly, rather than against the employer plans that you provide services to. HICA applies to all "paid claims" of third party administrators. "Paid claims" does not include claims paid for services rendered to non-residents, nor does the term include claims paid for services to Michigan residents that are rendered outside of the State. Accordingly, the term includes claims paid for services provided to Michigan residents that are rendered in Michigan.

Are vision-related services subject to the Health Insurance Claims Assessment (HICA)?

Yes. The HICA is levied on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." Section 2(s). "Health and medical services" is broadly defined to include services provided by a physician or other practitioner including, but not limited to, health professionals (other than certain specifically excluded health professionals), along with "ancillary services." Section 2(j). Assuming that such services result in "paid claims," vision-related services provided by an optometrist or an ophthalmologist, as well as those provided by an optician (such as providing and fitting eyeglasses or contact lenses) would be subject to the HICA.

Is "durable medical equipment" subject to the Health Insurance Claims Assessment (HICA)?

Generally, yes. While that term is not specifically mentioned or defined in the statute, the HICA is levied on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." Section 2(s). "Health and medical services" is broadly defined to include "services included in furnishing medical care." Section 2(j). If services related to the provision of medical equipment result in "paid claims," such services would be subject to the HICA, unless a specific statutory exemption applied to exclude those services.

Are claims for prescription drugs, purchased through a mail-order pharmacy and delivered to a Michigan resident, subject to the Health Insurance Claims Assessment (HICA)?

Yes. The assessment levied under HICA is on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services

provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." The term includes payments for claims for "service in this state by a pharmacy benefits manager." Section 2(s). "Health and medical services" is broadly defined to include services included in furnishing pharmaceutical benefits. Section 2(j)(i). Pharmaceutical services are provided to a Michigan resident "in this state" if the pharmaceuticals are delivered to that Michigan resident within the state of Michigan. This would apply to other mail-order prescription products as well, such as contact lenses, diabetic supplies, etc.

Are dental services subject to the Health Insurance Claims Assessment (HICA)?

Yes. The assessment levied under HICA is on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." Section 2(s). "Health and medical services" is specifically defined to include services included in "furnishing . . . dental care." Section 2(j)(i).

Are carriers of Medicare supplemental insurance subject to the assessment under the Health Insurance Claims Assessment (HICA) Act? Should claims paid under Medicare supplemental coverage be included when determining the amount of the assessment that must be paid?

Yes, in both cases. Carriers of Medicare supplemental insurance will be subject to the HICA assessment if they meet the definition of "carrier" in the statute and they do not fall under any of the statute's specific exemptions. MCL 550.1732(a). There is no specific statutory exemption for carriers of Medicare supplemental insurance. These carriers, and claims paid pursuant to their coverage, are included in the assessment.

The Health Insurance Claims Assessment (HICA) Act refers to "ambulatory services" as one type of health and medical service that is subject to the assessment. What are "ambulatory services"?

"Ambulatory services" (referenced in MCL 550.1732(j)(*ii*) of the HICA Act) are medical services that are provided on an outpatient basis. Many medical treatments for acute illness and many preventive health care procedures can be performed on an ambulatory basis, including minor surgical and medical procedures, most types of dental services, dermatology services, and many types of diagnostic procedures (e.g., blood tests, X-rays, endoscopy and biopsy procedures of superficial organs). Accordingly, paid claims for minor surgical procedures performed at an outpatient surgery center would be subject to the HICA Act assessment, as would claims for diagnostic procedures such as colonoscopies, where the patient receives services in a hospital setting but is checked in and out on the same calendar day.

For services provided by a pharmacist, does the Health Insurance Claims Assessment (HICA) apply to the price of the pharmaceutical products or drugs?

Yes, a covered "paid claim" for pharmacy services or pharmaceutical benefits includes the cost of the pharmaceutical products or drugs. MCL 550.1732(s).

We are a third party administrator that is subject to the Health Insurance Claims Assessment (HICA) Act. Doctors and other providers often use billing services, and we frequently pay claims where the medical service provided is billed through such a billing service. However, there is not necessarily an indication on the claim where the actual service was performed, and the billing service is sometimes in a different state than where the doctor or provider is located. How do we handle these kinds of claims for purposes of the HICA assessment?

If the medical service upon which a claim is based was performed outside of Michigan, that claim can validly be excluded from a third party administrator's calculation of "paid claims" upon which the HICA assessment must be paid. *See* MCL 550.1732(s). However, in all cases, it is the burden of the entity claiming a right to an exclusion or exemption from a tax or assessment to prove its entitlement to that exclusion or exemption.

Thus, if a third party administrator excludes certain claims on the basis that the underlying medical services were not performed in Michigan, the third party administrator must be able to prove upon audit that the services associated with those claims were, in fact, not performed in Michigan. If the proliferation of medical providers using billing services, including out of state billing services, means that the billing address or other information on a claim does not provide reliable evidence with respect to where the underlying medical service was actually performed, then it is incumbent upon the third party administrator to obtain additional information regarding the service performance location, if that claim is to be validly excluded. If the third party administrator is unable or chooses not to obtain that information, whether due to cost considerations or for other reasons, then those claims must be included in the calculation of "paid claims" that are subject to the HICA.

An employer pays a third party administrator to administer its wellness program, which includes a screening, a risk assessment, and an annual physical. Are such wellness expenses covered by the Health Insurance Claims Assessment (HICA)?

Yes. Wellness services such as those described in the question are not specifically excluded from the definition of "paid claims." *See* MCL 550.1732(s). In general, unless a type of health or medical service is specifically excluded from coverage under the statutory definition of "paid claims," claims based upon those services will be subject to the HICA.

Exclusions from “Paid Claims”

Are there health-related claims that the Health Insurance Claims Assessment (HICA) does not apply to?

Yes. The HICA Act assessment does not apply to:

- Payments for services provided before January 1, 2012;
- Claims paid for services provided to persons who are not residents of Michigan;
- Claims paid for services provided outside of Michigan to Michigan residents;
- Claims-related expenses;
- Claims paid under specified accident or accident-only coverage, credit, disability income, long-term care, automobile insurance, homeowners insurance, farm owners' insurance, commercial multi-peril coverage, worker's compensation, and coverage issued as a supplement to liability insurance;
- Claims paid under a federal employee health benefit program, Medicare, Medicare Advantage, Medicare Part D, Tricare, by the U. S. Veterans Administration and for certain high risk pools; and
- Reimbursements to individuals under a flexible spending arrangement, a health savings account, an Archer medical savings account, a Medicare Advantage medical savings account, or other health reimbursement arrangements authorized under federal law.

For more information, see the complete definition of "paid claims" set forth in the Act. MCL 550.1732(s).

The only service provided by a licensed Third Party Administrator (TPA) in Michigan is health care and dependent care flex benefit administration for a client. The TPA receives the employees’ payroll deductions for health and dependent care and makes reimbursements to these employees when they submit the required documentation showing out of pocket payments for co-pays etc. and dependent care costs. Are the payments made by the TPA subject to the assessment?

No. Pursuant to Section 2(s)(*viii*) of the Health Insurance Claims Assessment (HICA) Act, reimbursements made to individuals under a flexible spending arrangement are specifically excluded from the definition of "paid claims" subject to the assessment, provided that the flexible spending arrangement in question meets the definition of that term under Section 106(c)(2) of the Internal Revenue Code.

Our company, located in Michigan, is a self-insured entity for worker's compensation only. Does the Health Insurance Claims Assessment (HICA) Act apply to payments made on worker's compensation claims?

No. The assessment under the HICA Act is levied on the "paid claims" of covered entities. The definition of "paid claims" specifically excludes claims paid for worker's compensation. See MCL 550.1732(s)(*iii*).

Does the Health Insurance Claims Assessment (HICA) Act apply to an indemnity only insurance product? For example, the insured suffers a broken arm and the carrier pays $500 directly to the insured, regardless of treatment expense?

No, the assessment under the HICA Act would not apply to claims paid under an indemnity-only insurance product, such as that described in the question. Under the statute, a "paid claim" means an actual payment made to a health and medical services provider, or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier. MCL 550.1732(s). A claim under an indemnity-only policy would not be a "paid claim" under this definition, because the payment associated with the claim would not be made to a health and medical services provider, nor would it be a reimbursement to an individual.

Are payments made pursuant to a health reimbursement account excluded from the Health Insurance Claims Assessment (HICA) Act?

Probably. Among the exclusions from the HICA Act's definition of "paid claims" upon which the assessment must be paid are "reimbursements to individuals under a flexible spending arrangement as that term is defined in section 106(c)(2) of the internal revenue code, … a health savings account as that term is defined in section 223 of the internal revenue code, … an Archer medical savings account as defined in section 220 of the internal revenue code, … a Medicare advantage medical savings account as that term is defined in section 138 of the internal revenue code, … or other health reimbursement arrangement authorized under federal law." MCL 550.1732(s)(viii). If a claim constitutes a reimbursement made to an individual under a health reimbursement account that is specifically authorized pursuant to federal law, that claim would be excluded from the HICA Act's definition of a "paid claim."

If a payment from a health reimbursement account is made directly to a provider, would that payment be subject to the Health Insurance Claims Assessment (HICA)? The wording of the statute only specifically excludes payments made to individuals.

Among the exclusions from the HICA Act's definition of "paid claims" upon which the assessment must be paid are "reimbursements to individuals under a flexible spending arrangement as that term is defined in section 106(c)(2) of the internal revenue code, … a health savings account as that term is defined in section 223

of the internal revenue code, … an Archer medical savings account as defined in section 220 of the internal revenue code, … a Medicare advantage medical savings account as that term is defined in section 138 of the internal revenue code, … or other health reimbursement arrangement authorized under federal law." MCL 550.1732(s)(viii). If a claim constitutes a reimbursement made to an individual under a health reimbursement account that is specifically authorized pursuant to federal law, that claim would be excluded from the HICA Act's definition of a "paid claim."

If the health reimbursement account meets the requirements for the statutory exclusion as stated above, the payments would not fall outside of the exclusion simply because they were made to a provider, rather than reimbursed to an individual. In this case, the payments would be made to the provider from the health reimbursement account at the specific direction of the individual account holder. Those payments would not constitute "paid claims" and would not be subject to the HICA Act assessment.

How should "domestic claims" between hospitals and their employees be treated for purposes of the Health Insurance Claims Assessment (HICA) Act? Typically, when a hospital employee has treatment at the employer hospital, a claim is submitted for eligibility verification and internal accounting purposes, but no money is paid to the hospital for the services provided.

The HICA Act assessment is levied upon the "paid claims" of carriers and third party administrators. "Paid claims" is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." MCL 550.1732(s). The "domestic claims" described in the question would not meet the definition of "paid claim" under the HICA Act, because there is no "actual payment" being made to a health and medical services provider. These claims would not be subject to the HICA Act assessment.

Are carriers of Medicare supplemental insurance subject to the assessment under the Health Insurance Claims Assessment (HICA) Act? Should claims paid under Medicare supplemental coverage be included when determining the amount of the assessment that must be paid?

Yes, in both cases. Carriers of Medicare supplemental insurance will be subject to the HICA assessment if they meet the definition of "carrier" in the statute and they do not fall under any of the statute's specific exemptions. MCL 550.1732(a). There is no specific statutory exemption for carriers of Medicare supplemental insurance. These carriers, and claims paid pursuant to their coverage, are included in the assessment.

We are a dental insurance carrier. We are wondering how to handle the Health Insurance Claims Assessment (HICA) with respect to subrogated Medicaid claims. Do we pay the assessment on subrogated claims?

Yes. A claim for health and medical services is subrogated when Medicaid administration determines that all or part of a claim previously paid by Medicaid is, in fact, covered by private insurance. In the case of subrogated claims, assuming that the claim otherwise meets the statutory the definition of “paid claims,” the insurance company (or its third-party administrator, if applicable) must pay the HICA assessment on the portion of the claim for which the carrier is ultimately responsible. If a portion of the claim is still covered by Medicaid, that portion would not be subject to the claims assessment.

Are self-determination services paid by a Prepaid Inpatient Health Plan (PIHP) at the direction of a consumer subject to the Health Insurance Claims Assessment (HICA)?

Yes. As "specialty prepaid health plans," PIHPs are specifically defined as "carriers" under Section 2(a)(iv) of the HICA Act. Self-determination services are not specifically excluded from the definition of "paid claims." See MCL 550.1732(s). In general, unless a type of health or medical service is specifically excluded from coverage under the statutory definition of "paid claims," claims based upon those services will be subject to the HICA assessment, assuming that the entity paying the claims for such services meets the definition of a "carrier" or a "third party administrator" under the HICA Act. The fact that a payment may be made at the direction of a consumer is not relevant to a determination of whether the payment is subject to the HICA assessment.

A Program for All Inclusive Care for the Elderly (PACE) hires its own staff to handle patients, paying those individuals salaries. No personnel are paid on a per-claim basis. Is this subject to the Health Insurance Claims Assessment (HICA)?

No. A PACE does not meet the definition of a "carrier" under Section 2(a) of the HICA Act, and is therefore not liable for the assessment.

A Program for All Inclusive Care for the Elderly (PACE) contracts with other organizations to perform medical services, and pays those organizations a capitated payment every month. Is this subject to the Health Insurance Claims Assessment (HICA)?

A PACE does not meet the definition of a "carrier" under Section 2(a) of the HICA Act, and is therefore not liable for the assessment on the capitated payments made to the subcontracted organization. The subcontracted organization may or may not meet the definition of a "carrier" under the Act, but the organization would be the recipient of the payments in question, and not the payer. The capitated payments

would therefore not be "paid claims" as to the subcontracted organization, and not subject to the assessment.

Is a Program for All Inclusive Care for the Elderly (PACE) subject to the Health Insurance Claims Assessment (HICA)? These programs have outside providers perform medical services, and they are billed by and pay directly to these providers.

No. A PACE does not meet the definition of a "carrier" under Section 2(a) of the HICA Act, and is therefore not liable for the assessment.

Are claims for hospice care subject to the Health Insurance Claims Assessment (HICA)?

Yes. Services for hospice care are not specifically excluded from the definition of "paid claims." See MCL 550.1732(s). In general, unless a type of health or medical service is specifically excluded from coverage under the statutory definition of "paid claims," claims based upon those services will be subject to the HICA assessment, assuming that the entity paying the claims for such services meets the definition of a "carrier" or a "third party administrator" under the HICA Act.

Are claims paid with State general funds by a County Mental Health organization (CMH) for behavioral health services subject to the Health Insurance Claims Assessment (HICA)?

No. Because a CMH does not meet the definition of a “carrier” or a “third party administrator” under the HICA Act, claims or funds paid out by a CMH, regardless of the source of the funds, are not subject to the HICA assessment. This is also true for those CMHs that serve as Prepaid Inpatient Health Plans, because they are serving in the capacity of CMHs in this scenario. For “carriers” or “third party administrators,” however, claims for various types of health and medical services will generally be subject to the HICA assessment unless a service is specifically excluded from coverage under the statutory definition of “paid claims.” Because behavioral health services are not specifically excluded from the definition of “paid claims,” *see* MCL 550.1732(s), claims based upon these types of services will generally be subject to the HICA assessment.

Are claims processed on behalf of charitable, non-profit programs, such as programs providing free medical service to the uninsured, subject to the Health Insurance Claims Assessment (HICA)? What about claims processed for jailed inmates?

With the exceptions of Medicare, Medicare Advantage, and a few other funding sources listed in Section 2(s)(vii) of the statute, the source of funding does not determine whether the HICA assessment applies to a given claim. In most

instances, a carrier's "paid claim" will be subject to the assessment, regardless of the source of the money that the carrier uses to make that payment.

Each charitable program making payments or paying claims must determine if the program meets the definition of "carrier" under Section 2(a) of the Act, and if they have "paid claims" under Section 2(s). If so, the payments made by the program will be subject to the assessment. The same would be true for entities or organizations processing claims for jailed inmates.

Does the Health Insurance Claims Assessment (HICA) apply to MIChild and general fund claims paid to an organization?

In most cases, yes. With the exceptions of Medicare, Medicare Advantage, and a few other funding sources listed in Section 2(s)(vii) of the statute, the source of funding does not determine whether the HICA assessment applies to a given claim. In most instances, a carrier's "paid claim" will be subject to the assessment, regardless of the source of the money that the carrier uses to make that payment. If the carrier uses a third party administrator (TPA) to pay claims, however, then the TPA, and not the carrier, has the duty to pay the assessment. An entity or organization that does not use a TPA must determine whether they meet the definition of "carrier" under the HICA Act. If they do, their "paid claims" will be subject to the assessment.

Currently, Michigan's MIChild program is administered only by entities that would meet the statutory definition of "carrier" under the HICA Act. Therefore, the "paid claims" of those entities will be subject to the assessment.

We are a County Health Plan (CHP), a physical health organization that is paid capitation payments directly by the Michigan Department of Community Health to provide health care to beneficiaries of the Adult Benefit Waiver (ABW) program. Is this subject to the Health Insurance Claims Assessment (HICA)?

The TPA must pay the assessment. Although a CHP is not subject to the assessment because it does not meet the definition of a "carrier" under Section 2(a) of the Act, the assessment is also levied against TPAs. A TPA is liable for the assessment on all of its "paid claims," regardless of the status of the entity utilizing its services.

We are a Community Mental Health organization (CMH). CMHs receive capitated payments monthly from Medicaid for each member within our counties. Is this subject to the Health Insurance Claims Assessment (HICA)?

No. The HICA assessment applies to carriers, third party administrators, and self-insured entities that have "paid claims." While capitation payments themselves meet the statutory definition of "paid claims," CMHs do not fall within the definition of "carrier" under Section 2(a) of the Act.

However, if the CMH is also a Prepaid Inpatient Health Plan (PIHP), it will be considered a carrier (and thus, subject to the assessment) when acting as a PIHP, because PIHPs are specifically defined as carriers in Section 2(a)(iv). Additionally, if the CMH uses a third party administrator to pay claims, the third party administrator will be subject to the assessment regardless of the CMH's status as a carrier or non-carrier.

Are carriers of Medicare supplemental insurance subject to the assessment under the Health Insurance Claims Assessment (HICA) Act? Should claims paid under Medicare supplemental coverage be included when determining the amount of the assessment that must be paid?

Yes, in both cases. Carriers of Medicare supplemental insurance will be subject to the HICA assessment if they meet the definition of "carrier" in the statute and they do not fall under any of the statute's specific exemptions. MCL 550.1732(a). There is no specific statutory exemption for carriers of Medicare supplemental insurance. These carriers, and claims paid pursuant to their coverage, are included in the assessment.

We are a Prepaid Inpatient Health Plan (PIHP). We have outside providers perform services, and we are billed by and pay directly to these providers. Are we subject to the Health Insurance Claims Assessment (HICA)?

As "specialty prepaid health plans," PIHPs are specifically defined as "carriers" under Section 2(a)(iv) of the HICA Act. Payments made by a PIHP that meet the definition of "paid claims" under the Act are subject to the assessment. The term "paid claims" encompasses payments made for medical services performed by outside providers. If the PIHP has contracted with a third party administrator (TPA) or a pharmacy benefits manager to pay all or some of its claims, however, the TPA or PBM would have the obligation of paying the assessment, rather than the PIHP itself.

With the exceptions of Medicare, Medicare Advantage, and a few other funding sources listed in Section 2(s)(vii) of the statute, the source of funding does not determine whether the HICA assessment applies to a given claim. In most instances, a carrier's "paid claim" will be subject to the assessment, regardless of the source of the money that the carrier uses to make that payment.

We are a Medicaid Health Plan (MHP). We contract with other organizations to perform medical services, paying those organizations a capitated payment every month. The payment is for all eligible beneficiaries, and is not on a per-claim basis. Are we subject to the Health Insurance Claims Assessment (HICA)?

Yes. An MHP meets the definition of "carrier" under Section 2(a)(i) of the Act. The capitated payments made by the MHP to subcontracted organizations are encompassed by the definition of "paid claims" and are therefore subject to the assessment.

As a nonprofit dental care corporation, we contract to administer dental services to Medicaid beneficiaries through outside providers, and we are billed by and pay directly to these providers. Are we subject to the Health Insurance Claims Assessment (HICA)?

Yes. Nonprofit dental care corporations are specifically included in the definition of "carrier" under section 2(a)(iii). Therefore, all "paid claims" made by these organizations will be subject to the assessment.

Are SCHIP funds exempt from the Health Insurance Claims Assessment (HICA), like some other sources of federal funding?

With the exceptions of Medicare, Medicare Advantage, and a few other funding sources listed in Section 2(s)(vii) of the statute, the source of funding does not determine whether the HICA assessment applies to a given claim. In most instances, a carrier's "paid claim" will be subject to the assessment, regardless of the source of the money that the carrier uses to make that payment.

Currently, Michigan's MIChild program is administered only by entities that would meet the statutory definition of "carrier" under the HICA Act. Therefore, the "paid claims" of those entities will be subject to the assessment. The Medicaid MOMS program is administered as a fee-for-service program directly through the Michigan Department of Community Health (DCH). Since DCH is not a "carrier" under the HICA Act, these payments are not subject to the assessment.

Prepaid Inpatient Health Plans (PIHPs) contract with County Mental Health (CMH) agencies to perform services, paying the organization a capitated payment every month. Are we subject to the Health Insurance Claims Assessment (HICA)?

The assessment must be paid by the PIHP. As "specialty prepaid health plans," PIHPs are specifically defined as "carriers" under Section 2(a)(iv) of the HICA Act. Payments made by a PIHP that meet the definition of "paid claims" under the Act are subject to the assessment. The term "paid claims" encompasses capitated payments made to other organizations for medical services. A CMH is not a "carrier" under the Act, and is not liable for the assessment. If the PIHP has contracted with a third party administrator (TPA) or a pharmacy benefits manager to pay all or some of its claims, however, the TPA or PBM would have the obligation of paying the assessment, rather than the PIHP itself.

With the exceptions of Medicare, Medicare Advantage, and a few other funding sources listed in Section 2(s)(vii) of the statute, the source of funding does not determine whether the HICA assessment applies to a given claim. In most instances, a carrier's "paid claim" will be subject to the assessment, regardless of the source of the money that the carrier uses to make that payment.

We are a Prepaid Inpatient Health Plan (PIHP). We hire our own staff to handle all of our patients, and those individuals are paid salaries. We do not pay anyone on a per-claim basis. Are we subject to the Health Insurance Claims Assessment (HICA)?

As "specialty prepaid health plans," PIHPs are specifically defined as "carriers" under Section 2(a)(iv) of the HICA Act. Payments made by a PIHP that meet the definition of "paid claims" under Section 2(s) of the Act are subject to the assessment. Salaries paid to in-house staff for providing health and medical services are encompassed by the definition of "paid claims," because they are "actual payments… made to a health and medical services provider." These payments are therefore subject to the assessment.

With the exceptions of Medicare, Medicare Advantage, and a few other funding sources listed in Section 2(s)(vii) of the statute, the source of funding does not determine whether the HICA assessment applies to a given claim. In most instances, a carrier's "paid claim" will be subject to the assessment, regardless of the source of the money that the carrier uses to make that payment.

We are a County Health Department. We provide medical services both through our own in-house staff and through outside providers. Are we subject to the Health Insurance Claims Assessment (HICA)?

No. A County Health Department is not a "carrier" under the definition provided in Section 2(a) of the Act, and is therefore not subject to the assessment. Additionally, the County Health Department would be the recipient of the payments in question, and not the payer. The payments would not be "paid claims" as to the County Health Department, and thus would not be subject to the assessment. However, the entities paying claims from a County Health Department may be subject to the assessment. For example, MHPs meet the definition of "carrier" under the Act. The amounts paid by the MHPs to County Health Departments constitute "paid claims" that are subject to the HICA Act assessment. The MHPs are liable for the assessment on these payments.

We are a health plan that has been contracted by the Michigan Department of Community Health to provide medical services to beneficiaries under the MIChild program. Are we subject to the Health Insurance Claims Assessment (HICA)?

Yes. With the exceptions of Medicare, Medicare Advantage, and a few other funding sources listed in Section 2(s)(vii) of the statute, the source of funding does not determine whether the HICA assessment applies to a given claim. In most instances, a carrier's "paid claim" will be subject to the assessment, regardless of the source of the money that the carrier uses to make that payment.

All of the entities that currently administer the MIChild program meet the definition of "carrier" found in Section 2(a) of the HICA Act, and would therefore be liable for the assessment on their "paid claims."

The Health Insurance Claims Assessment (HICA) Act provides in Section 2(b)(ii) that "payments that are made to or by an organized group of health and medical service providers in accordance with managed risk arrangements or network access agreements. Does this fall under the Health Insurance Claims Assessment (HICA) Act?

Yes. MHPs fall within the definition of "carrier" under Section 2(a)(i) of the Act, and their "paid claims" are therefore subject to the assessment. Payments related to Graduate Medical Education (GME), Hospital Reimbursement Adjustments (HRA), Specialty Network Access Fees (SNAF), and the Child and Adolescent Health Center Program (CAHC) do not fit within the exception to "paid claims" outlined in Section 2(b)(ii) of the Act. Such payments are related to the provision of services to specific covered individuals, and therefore are not covered by the language of Section 2(b)(ii). These amounts are "paid claims" under Section 2(s) because they are "actual payments… made to a health and medical services provider," and they do not fit within any exception. MHPs are liable for the HICA Act assessment with respect to these payments.

Prescription Drugs and Pharmacy Benefit Managers

Are claims for prescription drugs, purchased through a mail-order pharmacy and delivered to a Michigan resident, subject to the Health Insurance Claims Assessment (HICA)?

Yes. The assessment levied under HICA is on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." The term includes payments for claims for "service in this state by a pharmacy benefits manager." Section 2(s). "Health and medical services" is broadly defined to include services included in furnishing pharmaceutical benefits. Section 2(j)(i). Pharmaceutical services are provided to a Michigan resident "in this state" if the pharmaceuticals are delivered to that Michigan resident within the state of Michigan. This would apply to other mail-order prescription products as well, such as contact lenses, diabetic supplies, etc.

For services provided by a pharmacist, does the Health Insurance Claims Assessment (HICA) apply to the price of the pharmaceutical products or drugs?

Yes, a covered "paid claim" for pharmacy services or pharmaceutical benefits includes the cost of the pharmaceutical products or drugs. MCL 550.1732(s).

Can rebates received by a Pharmacy Benefit Manager from drug companies be netted as "recoveries" against the PBMs "paid claims" for purposes of the Health Insurance Claims Assessment (HICA)?

In most cases, no. ""Recoveries" includes any amounts received by the payer that are applied against a claim, as long as the recovered amount affects the amount of the actual payment made to the provider. Rebates received by PBMs from drug companies do not typically affect the amount of the payment made to the medical services provider, which in this case is the pharmacy dispensing the drug.

We are a Pharmacy Benefits Manager (PBM). We process prescription drug claims for self-insured entities. We pay pharmacies for prescriptions that are filled, and then charge our employer client for that cost plus an administrative fee. Are we subject to the Health Insurance Claims Assessment (HICA) Act?

The assessment levied under HICAA is on "paid claims," which is defined as "actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." MCL 550.1732(s). If the PBM is acting as a third party administrator, as in the situation described above, the assessment would be calculated on the amount that the PBM pays to the pharmacy, because the pharmacy is the health and medical services provider. If the PBM is not acting as a third party administrator, and its claim must be processed through a separate third party administrator, then the assessment would be paid by the third party administrator and calculated on the amount paid to the PBM. The definition of “paid claims” under the statute specifically includes claims for service by a Pharmacy Benefits Manager. MCL 550.1732(s).

Are Pharmacy Benefits Managers responsible for paying the 1% assessment under the Health Insurance Claims Assessment Act (HICAA)?

In many cases, yes. The statute defines “third party administrator” as “an entity that processes claims under a service contract and that may also provide 1 or more other administrative services under a service contract.” MCL 550.1732(v). Frequently, Pharmacy Benefits Managers (PBMs) act as third party administrators, administering prescription drug programs, paying claims related to prescription drug benefits, and then obtaining repayment by directly charging the client health plan or employer group for their services. If a PBM meets the statutory definition of “third party administrator,” and the PMB obtains repayment by directly charging the health plan or employer group for its services, that PBM is responsible for paying the 1% HICAA assessment on the prescription drug benefit claims that it pays on behalf of the entities that it services. If, however, the PBM utilizes its own third party administrator or must otherwise obtain payment by submitting its claim to a separate third party administrator servicing the health plan or employer group, the third party administrator, and not the PBM, will be responsible for paying the 1% HICAA assessment on those claims. The definition of “paid claims” under

the statute specifically includes claims for service by a Pharmacy Benefits Manager. MCL 550.1732(s).

Medicaid-Related Services

We are a Medicaid Health Plan (MHP). We contract with outside providers to perform medical services, and we are billed by and pay directly to these providers. Are we liable for the Health Insurance Claims Assessment (HICA)?

Yes. An MHP meets the definition of "carrier" under Section 2(a)(i) of the Act. The payments made by the MHP to outside medical service providers are encompassed by the definition of "paid claims" and are therefore subject to the assessment.

We are a dental insurance carrier. We are wondering how to handle the Health Insurance Claims Assessment (HICA) with respect to subrogated Medicaid claims. Do we pay the assessment on subrogated claims?

Yes. A claim for health and medical services is subrogated when Medicaid administration determines that all or part of a claim previously paid by Medicaid is, in fact, covered by private insurance. In the case of subrogated claims, assuming that the claim otherwise meets the statutory the definition of “paid claims,” the insurance company (or its third-party administrator, if applicable) must pay the HICA assessment on the portion of the claim for which the carrier is ultimately responsible. If a portion of the claim is still covered by Medicaid, that portion would not be subject to the claims assessment.